RHODE ISLAND MEDICAL ASSISTANCE PROGRAM
AUTHORIZATION FOR DIRECT DEPOSIT

Complete the section below and attach a copy of a voided check for a checking account, or a copy of a deposit slip for a savings account. The transaction routing number can be obtained from your bank.

PROVIDER NAME	**PROVIDER NUMBER**

BANK NAME	**TRANSACTION ROUTING NUMBER**
BANK ADDRESS	**ACCOUNT NUMBER**
BANK PHONE NUMBER	
	CHECKING _____ SAVINGS_____

I agree to keep, and disclose upon request to authorized agencies, records which disclose fully the extent of payments claimed from the services rendered to recipients of the Medical Assistance Program. I accept as payment in full the amount paid by the Medical Assistance Program for claims submitted with the exception of authorized cost sharing by recipients. I understand payment of this claim is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to certify that the information submitted to obtain this payment is true, accurate and complete.

I authorize the electronic transfer of Rhode Island Medical Assistance payments made to the above provider number. I understand that I am responsible for the validity of the above information.

_____ _____

Signature Date

**********EDS USE ONLY**********

DATE RECEIVED	**INITIALS**
DATE SUBMITTED	**INITIALS**

REV. 01/31/01